DELAWARE AUTISM SURVEILLANCE AND REGISTRATION

AUTISM REGISTRY REPORTING FORM

Any case of an autism spectrum disorder (ASD) is reportable to the Delaware Autism Registry within one month of diagnosis. Follow-up reporting is due each year.

PATIENT INFORMATION

Child's Name: _____ (Last / First / MI) Date of Birth: _____/_____/_____ (MM / DD / YYYY)

Hospital of Birth: _____ Place of Birth: _____

Child's Address: _____ City: _____ State: _____ Zip: _____

Sex: _____M _____ F Phone: __(_____)_____

Race – check all that apply:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian: _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander: _____
- ☐ Other: _____

Ethnicity – Hispanic: ☐ Yes ☐ No

If Yes, please specify:

- ☐ Mexican, Mexican American, Chicano
- ☐ Puerto Rican
- ☐ Cuban
- ☐ Other: _____

Parent/Legal Guardian (name): _____ (Last / First / MI)

Address (if different than child): _____ City: _____ State: _____ Zip: _____

Age symptoms first noted: _____ County and State of Residence at time of Diagnosis: _____

Current Medication(s) (please specify): _____

_____

Diagnosis

_____Autistic Disorder _____Asperger's Disorder _____Pervasive Developmental Disorder _____Rett's Disorder

_____Childhood Disintegrative Disorder _____Other (please specify): _____

Date of Diagnosis: _____ Co-morbidities: _____

DIAGNOSTICIAN INFORMATION

Name: _____ (Last / First / MI / Title)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _(____)_____ Fax: _(____)_____ Licensure Type: _____

Highest degree attained: _____ Year attained: _____

Specialty: _____ Subspecialty: _____

Facility where diagnosis was made:

_____Private Practice (name): _____

_____Specialty Clinic (name): _____

_____Practice (name): _____

_____Hospital (name): _____

_____Other (name of facility): _____

Diagnostician Signature: _____ Reporting Date: _____

SUBMIT TO: Delaware Division of Public Health, Autism Surveillance System
Attention: Newborn Screening Program
Blue Hen Corporate Center, 655 Bay Road, Suite 216, Dover, DE 19901
Phone: 1-800-262-3030 or (302) 741-2990 Fax: (302) 741-8576

Instructions for Completing the Delaware Autism Surveillance System Reporting Form

Please submit within one month of diagnosis and annually.

PATIENT INFORMATION

Child's name: last name, first name, middle initial

Date of Birth: child's date of birth**,** month/day/year

Hospital of Birth: name of hospital where child was born

Place of Birth: city, state where child was born

Child's address: street address, city, state, and zip code

Sex: check male or female

Phone number: area code and phone number

Race: check all that apply; fill in "other" if needed

Ethnicity: check Hispanic Yes, or No; If Hispanic Yes, check the origin listed, or fill in "other" if needed

Parent or legal guardian: last name, first name

Parent or legal guardian address: (if different than child's)

Age symptoms first noted: the age when the symptoms of an Autism Spectrum Disorder (ASD) were first noted by parent, caregiver or physician

County and State of Residence at time of Diagnosis: county and state where patient lived at time of diagnosis

Current Medication(s): list all medications that the patient is taking at the time of diagnosis

Diagnosis: Check confirmed diagnosis

Date of diagnosis: date on which the diagnosis of an ASD was made

Co-morbidities: list any other condition(s) that co-exists with the ASD

DIAGNOSTICIAN INFORMATION

Name: name of diagnostician: last name, first name, middle initial, title

Address: street address, city, state, and zip code

Phone number: area code and phone number

Fax number: area code and phone number

Licensure Type: type of licensure, if any, attained by diagnostician

Highest Degree and Year Attained: highest degree and year attained by diagnostician

Specialty: diagnostician area of specialty

Subspecialty: diagnostician area of subspecialty, if any

Facility where diagnosis was made: check type of facility and fill in name of facility where diagnosis was made

Diagnostician Signature: signature of the person/diagnostician who made the diagnosis

Reporting Date: date the diagnostician reporting form was filled out